No-Fault Intake Form

Date:_____

Patient Name:_____Date of Birth:_____/_____/_____

Date of Accident:_____/_____/_____

Address:_____City_____ Zip Code_____

Cell Phone:_____ E-Mail:_____

Social Security #:_____Height:_____Weight_____Male( )Female ( )

Occupation:_____ Referred By:_____

Insurance Adjuster's name : _____

Phone #_____-_____-_____ E-Mail:_____

Insurance address_____

City:_____ Zip Code:_____

Insurance Company:_____

Claim #_____ Policy/FECA #_____

Insured's ID#_____

Attorney's name:_____

Phone #:_____ E-Mail:_____

Address: _____

City:_____ Zip Code:_____

Please list any previous doctors or healthcare professionals you have seen for THIS accident. Prodive their name, phone number, and dates of services. (Example: Dr. Smith - chiropractic, physical therapy, orthopedist, neurologist, ect. from Oct. 2021-June 2022)

_____
_____
_____
_____

What Hurts?_____

_____

Does it radiate/travel to another part of your body?_____

When does it hurt the most? _____

What feels better_____

What feels worse?_____

What is you pain RIGHT NOW - 0 1 2 3 4 5 6 7 8 9 10

What is your AVERAGE pain - 0 1 2 3 4 5 6 7 8 9 10

What is your pain level at its WORST- 0 1 2 3 4 5 6 7 8 9 10

What is your pain level at its BEST - 0 1 2 3 4 5 6 7 8 9 10

Please list 2 activities that you are having difficulty doing because of your pain. (Examples: playing a sport, carrying groceries, walking, exercising, ect.)

1._____0 1 2 3 4 5 6 7 8 9 10

2._____0 1 2 3 4 5 6 7 8 9 10

Describe how you felt IMMEDIATELY AFTER the accident:_____

LATER that day:_____

The NEXT day:_____

Did you have any physical complaints BEFORE the accident? Yes No

If yes, please explain _____

Did you have any PRIOR accidents or traumas? Yes No

If yes, please explain when

_____

_____

_____

Type of Accident: (please circle) Head on Collision, Broadside Collision, Rear End Collision, Front Impact, Rear Ended Car

Describe in your own words what happened to you upon impact

_____

_____

If you have had X-Rays, MRI's or CT's, where did you get them?

_____

Please check if you have or have had any of the following:

___Diabetes	___Asthma	___Headaches	___Depression	___Kidney Problems
___High Blood Pressure	___Thyroid Problems	___Prostate Problems	___Heart Disease	___Allergies
___Neck Pain	___High B/P	___Back Pain	___Digestive Problems	___Menstrual Problems
___Fibromyalgia	___Hormonal Problems	___Numbness	___Bladder Problems	___Asthma ___Sinusitis

Childhood Diseases:_____
Surgeries:_____
_____

Since this injury occurred are your symptoms: __improving __getting worse __same

Please check the symptoms you have noticed since the accident:

___Headaches	___Neck Pain	___Cold Sweats	___Jaw Pain/Clicking
___Back Pain	___Cold Feet	___Cold Hands	___Numbness in Hands
___Numbness in Toes	___Light Bothering Eyes	___Constipation	___Diarrhea
___ Lack of Organization	___Inability to Concentrate	___Irritability	___Chest Pain
___Dizziness	___Depression	____Shortness of Breath	___Buzzing In Ears
____Upset Stomach	___Fatigue	____Loss of Balance	___Fainting
____Fever	___Back Pain	____Sleeping Problems	___Tension
___Pins & Needles in Arms/fingers		___Pins & Needles in Legs/toes	___Nervousness
___Clicking in Jaw	___Emotional Instability		

Please check if you have been unable to perform the following activities:

___Coughing or Sneezing	___Balancing	___Lying Flat on Stomach	___Sexual Activity
___Climbing	___Dressing Self	___Lying on Back	___Pushing
___Gripping	___Getting In/Out of Car	____Kneeling	___Turning Over in Bed
___Sitting	___Bending Forward	___Standing	___Pulling
___Walking Short Distances			

1. By my signature below, I consent to examination and care at Kenul Chiropractic/O Light Body Bar. I authorize the doctors to obtain or release information regarding this care.
2. I attest under penalties of perjury that all information given is truthful and accurate as stated.
3. I assign benefits to Kenul Chiropractic/O Light Body Bar Office.

Signature:_____ Date:_____